MEDICAID SPENDDOWN PREPAYMENT IN ILLINOIS

REPORT OF A FEASIBILITY STUDY CONDUCTED PURSUANT TO HR 865

Illinois Department of Public Aid

George H. Ryan, Governor
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December 2002

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The Honorable Members of the Illinois House of Representatives

Dear Representative:

I am pleased to present this report in response to House Resolution 865 which directed the Department of Public Aid to complete a study of the feasibility of establishing a Medicaid spenddown prepayment program in Illinois.

As the report explains in detail, we have determined that a prepayment program could offer an essentially cost neutral way to make it easier for some individuals to qualify for Medicaid with a spenddown. Federal requirements, however, are administratively burdensome. Implementing such a program would entail extensive data system reprogramming by both DPA and DHS. For that reason, changes necessary for the prepayment program cannot be undertaken at least until reprogramming required by the Health Insurance Portability and Accountability Act is completed next October. We project that the earliest date for implementation of spenddown prepayment would be July 1, 2004.

Throughout our work on this report, we enjoyed excellent cooperation from the Department of Human Services as well as concerned advocates. I will take this opportunity to express my appreciation for their support.

Sincerely,

A. George Hovanec
Acting Director

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December 2002

EXECUTIVE SUMMARY

In response to House Resolution (HR) 865, the Department of Public Aid (DPA) in collaboration with the Department of Human Services (DHS) and interested advocates studied the feasibility of establishing a Medicaid spenddown prepayment program in Illinois. Such a program would permit persons to pay DPA the amount by which their incomes exceed the income threshold and thereby become eligible for full Medicaid benefits.

The prepayment option would be likely to benefit participants with small spenddown amounts who meet their spenddown on a regular basis. These participants would be able to attain and maintain their medical coverage with no break in benefits and with no contact with their DHS local office caseworker. This would simplify the program for both the participant and the local office caseworker.

Nonetheless, federal requirements make implementing a spenddown prepayment program administratively burdensome. DPA has experience in collecting premiums and some mechanisms in place to accept premiums, authorize medical benefits, and handle appropriate federal claiming. However, staff at the Centers for Medicare & Medicaid Services (CMS – formerly HCFA) has made it clear that the prepayment option is not a premium program and cannot be treated as such. Although this option has been available to states for ten years, only five states have implemented the prepayment option.

DPA could implement a prepayment program with extensive modifications to both DHS's and DPA's computer systems. In addition, DPA would require additional staff to interact with participants, coordinate with DHS local office staff, and process refund requests.

The estimated cost to implement this program is $876,000 the first year and $177,000 a year thereafter. This includes one-time system modifications of $699,000 ($255,000 for DPA and $444,000 for DHS) and ongoing yearly DPA staff expenses of $177,000.

The Department recommends that Illinois proceed to implement a spenddown prepayment program after system changes required by the Health Insurance Portability and Accountability Act are completed in October 2003. Allowing six to eight months for systems changes required for prepayment and assuming staff resources permit, the prepayment program could become effective July 1, 2004.

Report of the Feasibility of Establishing a Spenddown Prepayment Program in Illinois

December 2002

BACKGROUND

Medicaid Spenddown

Medicaid is a joint federal and state program authorized under Title XIX of the Social Security Act. The program as operated in Illinois is called medical assistance and is authorized by the Public Aid Code, 305 ILCS 5/1-1 *et seq*. Medical assistance also includes some individuals who are not eligible for Medicaid and whose medical benefits are paid solely with state funds. Through Medicaid, states finance medical benefits for persons found to be categorically eligible for the program. Persons who are aged or blind or persons with disabilities, pregnant women, children, and relatives caring for children who live with them are categorically eligible if they have income within the state's established threshold.

Under Title XIX, states can opt to provide benefits to individuals who would be categorically eligible except that they have too much income. This group is referred to federally as medically needy. Illinois has provided coverage to medically needy individuals under its medical assistance program since 1966. Spenddown is part of the medically needy coverage group.

Under spenddown, individuals who have too much income or too many assets to qualify for Medicaid can become eligible if they incur medical expenses in an amount equal to the amount by which their income or assets exceed the medically needy eligibility threshold. Individuals can have a spenddown due to excess income, excess assets, or a combination of excess income and excess assets.

Currently in Illinois, individuals can receive medical benefits for any month for which they provide proof of incurred medical expenses, whether paid or not, to their Department of Human Services (DHS) local office caseworker. Once an individual provides the proof, the caseworker completes a calculation and, if appropriate, authorizes medical benefits for each month spenddown is met.

As part of OBRA 1990 (P.L. 101-508), Congress expanded the medically needy spenddown program to permit states to allow individuals to prepay their spenddown amount to the state. See Appendix A. The federal term for this option is spenddown pay-in. (Note: throughout this report, the term prepayment has been used with the same meaning as pay-in.) The federal law allows states to choose whether to take this option. States that opt to implement spenddown prepayment must follow all applicable federal statutes, regulations, and directives.

Legislative History

House Bill 4944, sponsored by Representative Feigenholtz, and Senate Bill 1802, sponsored by Senator Radogno, requiring the Department of Public Aid (DPA) to implement a spenddown prepayment program were introduced but not passed in the spring 2002 session of the Illinois General Assembly. Representative Feigenholtz also sponsored HR 865 which passed. HR 865 directed DPA to conduct a feasibility study regarding implementing a Medicaid spenddown prepayment program. See Appendix B.

HR 865 directed DPA to analyze spenddown prepayment programs in other states. The resolution further directed DPA to estimate the number of individuals who would be eligible to participate as well as the projected number of eligible individuals who would be likely to participate. In addition, the study called for an analysis of how participants might or might not benefit from the program, a description of the administrative and policy changes that would be necessary and projected cost increases and cost savings that would result. HR 865 directed DPA to collaborate with advocates and DHS in conducting the study.

Study Protocol

DPA Director Jackie Garner established a study advisory committee consisting of advocates for services for individuals with disabilities who had expressed interest in HR 865. The committee also included appropriate staff from DPA and DHS. See Appendix C for a complete list of advisory committee members and state staff.

An initial meeting of the advisory committee was held on September 11, 2002 to discuss the study protocol. Committee members provided information from other states, discussed populations that might participate in a prepayment program, and identified the limitations that might prevent individuals from participating. Committee members also gave advice concerning how to estimate the numbers of individuals who might participate in the program. Committee members were encouraged to provide additional comments in writing. See Appendix D.

Subsequent to the first meeting of the advisory committee, DPA contacted other states that have a spenddown prepayment program. Staff sought and received guidance from the federal Centers for Medicare & Medicaid Services (CMS – formerly HCFA) regarding federal requirements for implementing a prepayment program. DPA also analyzed available data for individuals currently participating in Illinois' medical assistance program with a spenddown at various income levels. DPA assessed potential medical services costs and savings. Finally, DPA staff explored the administrative and operational requirements that would be associated with a spenddown prepayment program.

DPA summarized this work in a draft report that was discussed with the advisory committee members on November 18, 2002. After considering comments received from members of the committee, this final report was prepared.

FEDERAL SPENDDOWN PREPAYMENT REQUIREMENTS

Although the federal statute that allows the spenddown prepayment option establishes few requirements and federal regulations have never been issued, the State Medicaid Manual (SMM) lists several requirements that states must follow to implement the prepayment option. See Appendix E. The SMM is an official medium by which CMS issues mandatory, advisory, and optional Medicaid policies and procedures. Instructions in the SMM are official interpretations of the statutes and regulations.

According to the SMM, states that choose to offer spenddown prepayment must:

- develop a mechanism to accept cash payments;
- in any given month, allow an individual to use a combination of expenses and prepayment to meet spenddown;
- allow an individual to decide each month if they want to prepay, provide medical expenses, or use a combination of both;
- refund (or apply to a future month) any payments made for a month that exceed the amount expended by the state on behalf of the individual for medical expenses for the month; and
- refund any payments made to the state by the individual (or on their behalf) which the individual needs to purchase medical services not covered by Medicaid.

A careful review of these requirements illuminates the federal perspective that spenddown prepayments do not work like typical health insurance premiums. If the state does not make medical payments on behalf of a prepayment participant that are at least equal to the amount of the prepayment, the remaining prepayment continues to count as a credit to the participant.

ANALYSIS OF SPENDDOWN PREPAYMENT PROGRAMS IN OTHER STATES

DPA and the advisory committee members identified five states - Utah, Ohio, Minnesota, New York, and Missouri - that currently operate prepayment programs. DPA interviewed staff from each of the five.

Although the states operate their prepayment programs in slightly different ways, all five states accept cash payments in at least some of their offices. All five states also do a yearly reconciliation to refund or apply to a future month any unused payments made by the participant. Two of the states (Ohio, New York) also allow for a combination of prepayment and bills and receipts for any month. The other three do not.

Four of the states contacted have a favorable opinion of the prepayment option, particularly as it benefits participants. However, staff from two of the states advised that the program is administratively burdensome. Since Missouri just implemented its program in October 2002, staff there has not had enough experience to judge the success of their program.

Only Minnesota and Missouri operate the program centrally. The other three states use a manual process that operates completely at a local level. Minnesota estimates that approximately 300 persons take advantage of the prepay option monthly. Missouri received payments from 1,805 participants in the program's first month. This represented approximately 38% of the persons who met their spenddown for October.

Since the other three states operate the programs at a local level, the staff interviewed were unable to provide statewide data on participation.

ESTIMATE OF NUMBER OF ILLINOISANS WHO WOULD BE ELIGIBLE TO PARTICIPATE AND THE PROJECTED NUMBER WHO ARE LIKELY TO PARTICIPATE

The consensus of the advisory committee was that most individuals who would decide to prepay their spenddown would be those who had ongoing medical needs, such as prescription medication, therapy, or laboratory services **and** one or more of the following:

- relatively small monthly spenddowns of $75 or less, *or*
- had some assets, as well as income, which would give them the flexibility to commit to paying in advance; *or*
- were in situations where others would be motivated to prepay a spenddown for them, for example, parents of adult children with disabilities, other relatives, HIV service providers (including ADAP), mental health services providers, community residential placements for people with disabilities or people with strong ties to local religious groups or social service providers.

Some advisory committee members believed that individuals with disabilities would be the main participants because:

- most seniors are covered by Medicare which pays for 80% of their medical expenses other than prescriptions and SeniorCare is available to cover prescriptions for individuals with income under 200% of poverty, and
- families are unlikely to participate because, with the implementation of FamilyCare, the minimum monthly spenddown for an adult is over $100 and for a child over $1,000.

Based on the most recent data available, there are 3,566 individuals who met their spenddown with incurred bills and receipts at least 75% of the time in fiscal year 2002. Only 324 of these were part of families with children. The majority, 3,242, received benefits under the Aged, Blind, and Disabled (AABD) program. See the table in Appendix G.

Of the 3,566 individuals who met their spenddown 75% of the time, DPA estimates that approximately 654 individuals would be likely to participate each month. This is 50% of the 1,224 individuals with disabilities plus 50% of the 83 families who met their spenddown at least 75% of the time and had spenddowns of less than $75.

ANALYSIS OF HOW MEDICAID SPENDDOWN RECIPIENTS MAY OR MAY NOT BENEFIT FROM A SPENDDOWN PREPAYMENT PROGRAM

With the assistance of the advisory committee, DPA identified the following ways in which individuals could benefit from a prepayment program:

1. Individuals who prepaid timely would receive a MediPlan card prior to the month of coverage without the need for contacting their local DHS office and presenting medical bills.

2. Under a prepayment program, spenddown would provide more consistent coverage than it does as operated currently in Illinois. An individual would know that when a medical need for a covered service arose, coverage would be in effect.

3. Family members or other organizations could make the payment directly to DPA on behalf of the participant.

Individuals would probably not benefit from a prepayment program if:

1. They have a large spenddown.

2. They do not have ongoing need for regular medical services.

3. They only meet spenddown sporadically.

4. They meet spenddown with bills or receipts from a time period before they were enrolled in spenddown.

ADMINISTRATIVE, POLICY AND SYSTEM CHANGES NECESSARY

Assessment of Federal Requirements

The federal requirements for a prepayment program would be difficult to administer. The most notable problems associated with them follow:

1. Accepting cash. Neither DPA nor DHS has an existing statewide structure for receiving cash payments from participants for any purpose. DHS strongly indicated that it would not be feasible for local offices to accept cash. Staffing concerns, security, and audit issues would make it unworkable. In part for this reason, with the

implementation of KidCare Premium and Health Benefits for Workers with Disabilities, both of which require participants to pay premiums, DPA asked participants in those programs to pay by check, money order or credit card.

2. Combining paid or incurred medical expenses with a prepayment. This requirement necessitates reprogramming DHS and DPA data systems that might not be cost-effective if, as expected and described later, a relatively small number of individuals opt to use prepayment.

3. Refunding prepayment amounts in excess of expenditures. This requirement also necessitates reprogramming DHS and DPA data systems. Since medical providers can take up to a year to bill for services, reconciliation of prepayment accounts could not occur until DPA was confident that all bills for services provided to the participant had been received.

4. Refunding amounts needed for noncovered services. DPA's claims processing system is designed to assure that payment is not made for noncovered services, and DPA does not establish rates for such services. It would not be prudent to attempt to reprogram the system to allow such payment for prepayment participants or to pay providers directly for those services. DPA would be required to use a manual process to reimburse participants who submitted evidence that they had paid for medical services not covered by medical assistance.

DPA proposed to the advisory committee that treating spenddown prepayments like insurance premiums was a much more feasible way of administering a prepayment program. The advocates generally agreed with this approach as fair and still beneficial to participants. Consequently, with the support of the advisory committee, DPA developed an alternate program design and submitted it informally to CMS for comment. DPA proposed treating a prepayment more like an insurance premium payment. The proposal and CMS's response are included as Appendix F.

CMS staff advised that DPA's proposal would not be approved because CMS will not permit a state to vary from the requirements of the SMM. The CMS representative stated that the administrative complexity of prepayment is the reason that so few states have taken advantage of this option in over ten years. The CMS staff representative also cautioned the state to consider the administrative cost and complexities involved in implementing the option in relation to the possible benefit it may offer.

Based upon the guidance received from CMS and the suggestions of the advisory committee and DHS, DPA used the following program design to assess the potential costs and administrative burden that would be associated with implementing a spenddown prepayment program. Implementation would be possible only if the resources necessary for staffing and data system programming could be identified. This would mean obtaining new resources or diverting resources from another activity.

1. DPA and DHS would share in the operation of the program. DPA would accept and process prepayments. DHS local offices would continue to receive and review receipts and bills for medical services. This would require significant changes to

DHS's Client Information System (CIS) particularly the Automated Intake System (AIS) and the Automated Spenddown System (ASDS) so that access to participant records could be shared. This would require changes to DPA's Public Aid Accounting System (PAAS) and the Medicaid Management Information System (MMIS) particularly, the Recipient Data Base (RDB). This would add a new function to and increase the workload of DPA's Bureau of Fiscal Operations. DPA would also require additional central casework staff.

2. Individuals who are aged, blind, or disabled would be able to participate in the prepayment program at such time as they had sufficient medical expenses to meet their spenddown or had a monthly spenddown of less than $150.

   Individuals are not Medicaid eligible until they meet their spenddown. As described above, DHS would not collect prepayments. Consequently, setting the $150 pay-in limit for persons who do not meet their spenddown with expenses would allow the state to add to the data base only individuals who are likely to become eligible by sending DPA their prepayment.

   To do otherwise would artificially inflate the eligibility workers' caseloads through enrollment of the tens of thousands of individuals who apply but never meet spenddown and never attain eligibility. Setting the cap would also permit DPA to avoid the expense and confusion of unnecessarily sending prepayment notices to thousands of individuals who would be unlikely to prepay because of high spenddown amounts.

3. Individuals could choose on a month-to-month basis whether to meet spenddown by prepaying the spenddown amount or by providing medical expenses, including those incurred in prior months, or a combination of both. Individuals could change their choices each month. This would require close integration of DHS and DPA data systems.

4. DPA would establish a cut-off date for receipt of the prepaid spenddown amount. This date would probably fall near the beginning of the month prior to the month of coverage. If the prepayment were received by the cut-off date, coverage would be authorized and the individual would receive a MediPlan card.

   If the prepayment were not received by the cut-off date, coverage would still be authorized but the participant would not have a MediPlan card prior to the first day of the coverage month. Keeping an accurate accounting of partial payments as well as spenddown amounts partially met with medical bills or receipts would require elaborate system design changes by both DPA and DHS.

5. Participants would be encouraged to use money orders, cashier's checks and credit cards. Cash would be accepted as payment only if it were received in Springfield.

6. DPA would probably not reconcile prepaid amounts to state medical expenditures until at least twelve months had elapsed since the coverage month. This would assure that all claims for medical services in the coverage month had been received.

This would require data system programming to assure integration of information from PAAS with information in the RDB.

7. DPA would not pay providers directly for noncovered services needed by participants. Participants could submit receipts one time per month for reimbursement of amounts they had paid for such services and DPA would issue a C-13 voucher to generate a refund through the Comptroller. DPA would handle this process manually.

Administrative Changes

To implement the program as described above, the following administrative changes would be necessary.

1. DPA would need accounting staff at a central location to process and post prepayments.

2. DPA would need casework staff at a central location to maintain prepayment case accounts including answering questions and solving problems for participants.

3. DPA would have to change its federal claiming process to report correctly and receive the appropriate federal reimbursement.

4. DHS staff would have to learn new processes for enrolling individuals in prepayment as well as explaining the option.

Policy Changes

DPA would issue a policy release, promulgate administrative rules and obtain approval from CMS for a Medicaid State Plan Amendment.

System Changes

As mentioned above, there are four major DHS and DPA data processing systems that would be involved in operating a spenddown prepayment program. DHS' CIS, which holds eligibility data and generates medical cards, would need to be modified. Other parts of CIS, particularly AIS, which is used by caseworkers to determine whether an applicant is eligible for medical assistance, and ASDS, which calculates whether spenddown is met, would require major enhancements. DPA's MMIS, particularly the RDB, which contains medical assistance eligibility data and processes claims for payment, and PAAS, which posts payments and communicates with the other systems, would also require major enhancements to allow for communication with other systems and to complete the yearly reconciliation and issue refunds, if appropriate. All three of these systems would require significant modification.

The following specific system changes have been identified:

1. DHS's CIS would need to be modified so that spenddown could be marked as met through system interfaces when a prepayment was received and recorded by DPA. The federal requirement that other medical expenses be used in combination with prepayment would require extensive communication between the various systems. This would be unique to the prepayment program and has not previously been programmed for DPA's premium payment programs. CIS would also need changes to effectively communicate with DPA's MMIS system to authorize coverage and issue refunds, as appropriate.

2. PAAS would need to be modified to post payments correctly, communicate with other systems, and ensure that federal match is claimed accurately.

3. DPA's MMIS would need to be modified to post eligibility, complete the reconciliations, communicate with other systems and issue any necessary refunds.

PROJECTED COST INCREASES OR COST SAVINGS

DPA Medical Services Costs. DPA does not anticipate any cost savings with the implementation of a spenddown prepayment program. Services costs would be expected to stay the same or increase slightly if more individuals met spenddown regularly or used more services as a result of having coverage for an entire month. Nonetheless, DPA does not expect significant increases in services costs associated with a spenddown prepayment program.

DPA's actual spending would increase, as the department would use prepaid funds to pay medical bills on behalf of prepayment participants and make refunds. This would not result in additional demands on state revenues, as expenditures would not exceed the value of prepayments received. The additional spending against appropriations would be expected to fall well under $500,000 a year if participation estimates prove accurate.

DHS Local Office Casework Staff. Since the prepayment program would entail both medical expenses and prepayments, DHS does not anticipate any workload reduction with implementation of the program. Caseworkers in each of the 120 DHS local offices across the state would need to understand the program and learn the new eligibility rules and processing procedures.

DPA Bureau of Fiscal Operations (BFO). BFO would be responsible for the receipt and posting of all payments made by participants. Refunds of spenddown amounts and payments for non-covered services would be paid by C-13 vouchers using PAAS. All prepayments would be sent to BFO in Springfield for centralized processing. Once a prepayment was received by BFO, it would be recorded and a transaction would be posted to PAAS. Required information for posting the receipt would be the participant's Social Security Number, medical assistance case number and Recipient Identification Number. Credit card payments would follow the same procedure as currently used for KidCare Premium and Health Benefits for Workers with Disabilities. Consequently, there would be an increased workload for BFO staff. PAAS would interface with the RDB, crediting the participant's case for the amount of the prepayment. Periodic reconciliations of receipts, interaction with program staff regarding questionable receipts, and the handling of any non-sufficient funds checks would all result in additional work for BFO.

Based on these activities, the anticipated personnel needs for BFO associated with the spenddown prepayment would be two accountant level full-time employees (FTEs) with a total annual cost in salary, benefits, and support of $107,000.

A new PAAS extract program would have to be created or an existing one modified, document processor modifications might be required, a reconciliation flag would have to be created to trigger the aged return file to MMIS, and an input interface with MMIS would have to be created. The following specific changes have been identified:

- Create an input interface for the return refund file from MMIS.
- Modify the cash receipt document to carry the service period.
- Modify the cash receipt holding tables to carry the service period and a reconciliation flag to trigger the aged return file to MMIS.

Programming these changes is estimated to take three staff approximately twenty-four weeks at a cost of approximately $150,000.

Total costs for BFO to implement would be $257,000.

DPA Central Office Casework Staff. DPA would have to provide central staff as needed to resolve case specific problems, interact with DHS local offices to coordinate work on particular cases, review financial reports to determine appropriate refunds, receive and evaluate participant requests for reimbursement for noncovered services, generate C-13 vouchers to BFO as necessary for reimbursements, and provide customer service in response to phone calls and other requests for assistance. This work is expected to require at a minimum the support of one FTE Human Service Caseworker and one-quarter FTE clerical support at a cost of approximately $70,000 annually for salaries, benefits, and supports.

DPA MMIS Data Programming. The cost estimate described for MMIS to perform yearly spenddown refund reconciliation is based on the following assumptions:

- A file of recipients who could potentially receive a refund via the reconciliation process will be created from PAAS. The file will contain at least the recipient identification number, Social Security Number, case ID, name, and service dates.

- The information from the PAAS file will be matched against MMIS recipient eligibility history to ensure that each recipient is eligible for the specified service dates.

- Recipients with verified eligibility will be matched against MMIS claims history data to determine if any medical services have been paid based on the service dates provided in the PAAS file.

    - A file containing the reconciliation results will be created from MMIS. This file will identify which recipients should receive a refund. The PAAS system will use this file to create each recipient's refund payment.

PROJECT TASK	TIME ESTIMATE	COST ESTIMATE
1 staff to complete analysis and program specifications for the eligibility verification	5 days	$3,000
1 staff to complete program coding and testing for the eligibility verification	10 days	$6,000
2 staff to complete analysis and program specifications for the claims history match	10 days	$12,000
2 staff to complete program coding and testing for the claims history match	30 days	$36,000
2 staff to coordinate user testing for the claims history match	30 days	$36,000
2 staff to complete production implementation tasks	10 days	$12,000
TOTAL COSTS	95 days	$105,000

DHS CIS Data Programming. The following estimate is based on initial specifications. It is understood that those initial specifications would most certainly be revised over the life of the project. Future changes or clarifications of specifications would impact the estimate of effort. The bottom line estimate calls for 37 man months. Based on 20 days per month and 8 hours per day, this results in a total of 5,920 hours. Contractual staff would perform most of this work. Therefore, the estimated costs were based on the average hourly rate of $75 for contractual services for a total of $444,000. Further details of this estimate are provided below.

PROJECT TASK	TIME ESTIMATE	COST ESTIMATE
2 System Analysts to define requirement with user	40 days	$24,000
1 System Analyst and 1 Programmer to modify programs for new bill type:		
AIS 30 programs	80 days	$48,000
ACM 40 programs	80 days	$48,000
1 System Analyst and 1 Programmer to implement modification to code 396:		
AIS 12 programs	40 days	$24,000

ACM/IPACS 10 programs	40 days	$24,000
1 System Analyst and 1 Programmer to define new files: AIS ACM	 40 days 40 days	 $24,000 $24,000
1 System Analyst and 1 Programmer to add new client notice print: AIS/ACM	 40 days	 $24,000
1 System Analyst and 1 Programmer to modify Forms Subsystem: AIS ACM	 40 days 40 days	 $24,000 $24,000
1 System Analyst and 1 Programmer to develop new spenddown change report: ACM	 40 days	 $24,000
1 System Analyst and 1 Programmer to implement modifications to allow change in "met status" ACM 10 programs	 40 days	 $24,000
1 System Analyst and 2 Programmers to develop new process to process a file from PAAS system: ACM	 180 days	 $108,000
TOTAL COSTS	740 days	$444,000

Total Projected Costs. Implementation of spenddown prepayment as described above would cost DPA approximately $432,000 and DHS approximately $444,000 in the first year for a combined total of $876,000. The ongoing annual costs of supporting the program are estimated to be approximately $177,000.

SUMMARY OF FINDINGS

The prepayment option could be attractive to individuals with small spenddowns who meet spenddown on a regular basis. Some individuals would be able to attain and maintain their medical assistance with no break in coverage and with no action on the part of their DHS local office caseworker. Social service and other community-based agencies and family members would also be able to assist participants by paying the spenddown directly to DPA. There would, however, be significant administrative costs involved in implementing the program due to federal mandates on program operation.

RECOMMENDATIONS

The Department recommends that Illinois proceed to implement a spenddown prepayment program after system changes required by the Health Insurance Portability and Accountability Act are completed in October 2003. Allowing six to eight months for systems changes required for prepayment and assuming staff resources permit, the prepayment program could become effective July 1, 2004.

LIST OF ABBREVIATED TERMS

AABD	Aid to the Aged, Blind and Disabled
ACM	Automated Case Management
ADAP	AIDS Drug Assistance Program
AIS	Automated Intake System
ASDS	Automated Spenddown System
BFO	Bureau of Fiscal Operations
CIS	Client Information System
CMS	Centers for Medicare & Medicaid Services
DHS	Department of Human Services
DPA	Department of Public Aid
FTE	Full-time Equivalent Employee
HBWD	Health Benefits for Workers with Disabilities
HIV	Human Immunodeficiency Virus
HR	House Resolution
MMIS	Medicaid Management Information System
PAAS	Public Aid Accounting System
RDB	Recipient Data Base
SMM	State Medicaid Manual

APPENDIX A

Social Security Act, Title XIX Section 1903(f) (42 U.S.C. sec. 1396b(f)

TITLE 42, CHAPTER 7, SUBCHAPTER XIX, Sec. 1396b

(f) Limitation on Federal participation in medical assistance

(1)

(A)

Except as provided in paragraph (4), payment under the preceding provisions of this section shall not be made with respect to any amount expended as medical assistance in a calendar quarter, in any State, for any member of a family the annual income of which exceeds the applicable income limitation determined under this paragraph.

(B)

(i)

Except as provided in clause (ii) of this subparagraph, the applicable income limitation with respect to any family is the amount determined, in accordance with standards prescribed by the Secretary, to be equivalent to 133 1/3 percent of the highest amount which would ordinarily be paid to a family of the same size without any income or resources, in the form of money payments, under the plan of the State approved under part A of subchapter IV of this chapter.

(ii)

If the Secretary finds that the operation of a uniform maximum limits payments to families of more than one size, he may adjust the amount otherwise determined under clause (i) to take account of families of different sizes.

(C)

The total amount of any applicable income limitation determined under subparagraph (B) shall, if it is not a multiple of $100 or such other amount as the Secretary may prescribe, be rounded to the next higher multiple of $100 or such other amount, as the case may be.

(2)

(A)

In computing a family's income for purposes of paragraph (1), there shall be excluded any costs (whether in the form of insurance premiums or otherwise and regardless of whether such costs are reimbursed under another public program of the State or political subdivision thereof) incurred by such family for medical care or for any other type of remedial care recognized under State law or,

(B)

notwithstanding section 1396o of this title at State option, an amount paid by such family, at the family's option, to the State, provided that the amount, when combined with costs incurred in prior months, is sufficient when excluded from the family's income to reduce such family's income below the applicable income limitation described in paragraph (1). The amount of State expenditures for which medical assistance is available under subsection (a)(1) of this section will be reduced by amounts paid to the State pursuant to this subparagraph.

(3)

For purposes of paragraph (1)(B), in the case of a family consisting of only one individual, the ''highest amount which would ordinarily be paid'' to such family under the State's plan approved under part A of subchapter IV of this chapter shall be the amount determined by the State agency (on the basis of reasonable relationship to the amounts payable under such plan to families consisting of two or more persons) to be the amount of the aid which would ordinarily be payable under such plan to a family (without any income or resources) consisting of one person if such plan provided for aid to such a family.

(4)

The limitations on payment imposed by the preceding provisions of this subsection shall not apply with respect to any amount expended by a State as medical assistance for any individual described in section 1396a(a)(10)(A)(i)(III), 1396a(a)(10)(A)(i)(IV), 1396a(a)(10)(A)(i)(V), 1396a(a)(10)(A)(i)(VI), 1396a(a)(10)(A)(i)(VII), 1396a(a)(10)(A)(ii)(IX), 1396a(a)(10)(A)(ii)(X), 1396a(a)(10)(A)(ii)(XIII), 1396a(a)(10)(A)(ii)(XIV), or (FOOTNOTE 2) 1396a(a)(10)(A)(ii)(XV), 1396a(a)(10)(A)(ii)(XVI), 1396a(a)(10)(A)(ii)(XVII), 1396a(a)(10)(A)(ii)(XVIII), 1396d(p)(1) of this title or for any individual –

(A)

who is receiving aid or assistance under any plan of the State approved under subchapter I, X, XIV or XVI, or part A of subchapter IV, or with respect to whom supplemental security income benefits are being paid under subchapter XVI of this chapter, or

(B)

who is not receiving such aid or assistance, and with respect to whom such benefits are not being paid, but

(i)

is eligible to receive such aid or assistance, or to have such benefits paid with respect to him, or

(ii)

would be eligible to receive such aid or assistance, or to have such benefits paid with respect to him if he were not in a medical institution, or

(C)

with respect to whom there is being paid, or who is eligible, or would be eligible if he were not in a medical institution, to have paid with respect to him, a State supplementary payment and is eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1396a(a)(10)(A) of this title, or who is a PACE program eligible individual enrolled in a PACE program under section 1396u-4 of this title, but only if the income of such individual (as determined under section 1382a of this title, but without regard to subsection (b) thereof) does not exceed 300 percent of the supplemental security income benefit rate established by section 1382(b)(1) of this title,

at the time of the provision of the medical assistance giving rise to such expenditure.

APPENDIX B

HOUSE RESOLUTION 865

WHEREAS, Approximately 100,000 Illinoisans qualify for Medicaid only by first spending down their monthly income on medical bills to the Medicaid eligibility level (currently $608 per month for a single adult and $822 per month for a married couple); and

WHEREAS, The process of verifying that these Illinoisans have spent down their monthly income on medical bills to the Medicaid eligibility level is often cumbersome and time-consuming for both recipients and local office staff of the Department of Human Services; and

WHEREAS, Federal law permits the Department of Public Aid to give Illinoisans enrolled in Medicaid spenddown the option of pre-paying their spenddown amount in a manner similar to a monthly insurance premium; and

WHEREAS, Having the option of pre-paying their Medicaid spenddown amount is likely to benefit many Illinoisans on Medicaid spenddown, who would then be able to receive a Medicaid card each month without delay and without having to present bills and receipts to their local Department of Human Services office each month; and

WHEREAS, Several states have established successful Medicaid spenddown pre-payment programs; therefore, be it

RESOLVED, BY THE HOUSE OF REPRESENTATIVES OF THE NINETY-SECOND GENERAL ASSEMBLY OF THE STATE OF ILLINOIS, that the Department of Public Aid is directed to:

(1) Conduct a study of the feasibility of establishing a Medicaid spenddown pre-payment program in Illinois, including, but not limited to, (i) an analysis of spenddown pre-payment programs in other states, (ii) an estimate of the number of Illinoisans who would be eligible to participate in

a spenddown pre-payment program, (iii) the projected number of eligible individuals who are likely to participate in a spenddown pre-payment program, (iv) an analysis of how Medicaid spenddown recipients may or may not benefit from a spenddown pre-payment program, (v) a description of administrative and policy changes that would be necessary to implement a spenddown pre-payment program, and (vi) projected cost increases and cost savings that would result from the implementation of a spenddown pre-payment program;

(2) Collaborate with the Department of Human Services, advocates for Medicaid spenddown recipients, and other interested parties in designing and conducting the feasibility study; and

(3) File a written report with the House of Representatives on or before March 31, 2003, regarding the feasibility of implementing a Medicaid spenddown pre-payment program in Illinois; and be it further

RESOLVED, That the Department of Human Services shall cooperate in executing the requirements of this Resolution; and be it further

RESOLVED, That a copy of this Resolution be sent to the Director of Public Aid and to the Secretary of Human Services.

APPENDIX C

Spenddown Prepayment Feasibility Study Advisory Committee Members

Mike Bach representing Frank Anselmo, Community Behavioral Health Association of Illinois
John Eckert, Statewide Independent Living Council
Ann Fisher, AIDS Legal Council of Chicago
Ann Ford, Illinois Network of Centers for Independent Living
Robert Gilligan, Catholic Conference of Illinois
Susan Jennings representing Don Moss, United Cerebral Palsy of Illinois
Phil Milsk, Attorney at Law
Courtney Snyder, SSI Coalition
Thomas Yates, SSI Coalition
Vickie Wilson, Coalition of Citizens with Disabilities of Illinois

DPA Staff

Jacquetta Ellinger, Deputy Administrator, Division of Medical Programs
John Rupcich, Bureau of Medical Eligibility Policy
Vicki Mote, Bureau of Medical Eligibility Policy
Pat Curtis, Health Benefits for Workers with Disabilities
Bill Dart, Legislative Liaison
Andy Kane, Bureau of Rate Development and Analysis
Brian Brinker, Division of Finance and Budget

Legal Counsel to DPA, Owen Field, General Counsel

DHS Staff

Mary Ann Langston, Associate Director, Office of Financial Support Services
David Peterson, Deputy General Counsel
Kit Sponsler, Bureau of Community Operations
Robert Doyle, Office of Legislation

APPENDIX D

Written Suggestions from Advisory Committee Members

October 2, 2002

Vicki Mote
Illinois Department of Public Aid
201 South Grand Avenue East
Springfield, IL 62763-0002

Re: Medicaid Spenddown Pre-payment Program

Dear Ms. Mote:

I am writing on behalf of Courtney Snyder and Thomas Yates of the SSI Coalition for a Responsible Safety Net, as well as on behalf of the AIDS Legal Council of Chicago. The Department asked us to provide our thoughts on the following issues:

What Should The Program Look Like

We have envisioned that the Medicaid Spenddown Pre-payment Program would make Medicaid look, for those who choose this option, more like traditional health insurance. Inherent in this is the following:

, Premiums would be set based on an individual's income and asset spenddown amount and would remain unchanged for 6-12 months at a time (unless the individual's countable income and assets changed);

, Premiums would be paid to a central location, preferably by mail or telephone using means of payment other than cash (check, money order, credit card, or automatic withdrawal) on a monthly basis, although the system would allow payment of multiple months in the future at the spenddown enrollee's option;

, Participants would not be able to submit a combination of bills and premiums to meet their spenddown but would have to elect one or the other;

, Premiums, once paid for a specific month, would not refundable or transferable to different months of Medicaid coverage if no bills were received in the month for which the premium was originally paid; and

, Premiums could be paid by third parties for the benefit of spenddown

enrollees.

2. Who Is Eligible?

As we discussed at our meeting on September 11, all persons now eligible for spenddown would be eligible to prepay their spenddown amounts. This would mean that both AABD-MANG and TANF-MANG spenddown enrollees would be eligible to prepay their spenddown amounts.

3. Who Will Actually Prepay to Enroll and What Factors Will Influence This Decision?

Having said that, we believe that most people who decide to prepay their spenddown amounts will have the following characteristics:

, have ongoing medical needs such as need for prescribed medications, therapy, medical checkups, laboratory services, or other services or items used regularly; ***and* one of more of the following:**

, have relatively small monthly spenddown amounts ($50 and under), *or*

, are in situations where others are motivated to prepay a spenddown for them, e.g. parents of adult children with disabilities, HIV service providers (including ADAP), mental health service providers, community residential placements for people with disabilities, or people with strong ties to local religious groups or social service providers, *or*

, have some assets, as well as income, which would give them the flexibility to commit to paying in advance.

4. Who will *not* be likely to enroll in a prepay option?

We believe that Medicaid beneficiaries with the following characteristics will be less likely (and in many of these situations, far less likely) to participate in a prepay option:

, TANF families, because a) parents, as a group, are younger and healthier than the AABD population, which makes it less likely that they will see benefit in paying spenddown. If they do have chronic health problems, then the financial incentives of increased household income would already lead to apply for SSI, moving them from the TANF population to the AABD population; and b) because the income eligibility limit for the TANF population is so low, and spenddown amounts so correspondingly high, that these families are simply unlikely to be able to afford the prepayment out of their current income.

, Pregnant women, because the eligibility limit is already fairly generous, at 200% of poverty, and because prenatal care is relatively inexpensive. The only high cost item for most individuals in this group is labor and delivery, which hospitals now are able to bill and receive payment minus the spenddown amount. In addition, because women in active labor cannot be denied treatment, there is no concern that a woman in labor will be denied treatment if she does not have a medical card, in contrast, for example, to someone with pharmacy needs, who will generally not be able to get those needs met unless he or she already has a medical card.

, Seniors, because virtually all seniors, regardless of income, are covered by Medicare for their inpatient, outpatient, and laboratory charges, and because seniors up to 200% of the FPL are eligible for comprehensive prescription drug coverage under SeniorCare. Although seniors with incomes over 200% of the FPL are not eligible for SeniorCare, their prepay amounts would be very high–at least $738 per month–so that unless they have extraordinarily high uncovered pharmacy bills it would not be cost-effective for them to participate in the prepay program.

, Individuals who are already living at or beyond their means, so that they do not have disposable income or assets to use to prepay their spenddown and do not have an organization or family member able or willing to pay it for them.

5. How to Estimate Who will Enroll

We believe that the number of people who will participate in a spenddown prepay program is a subset of disabled (not aged) AABD population in spenddown unmet status.

We do not know if the Department is able to determine, though sampling or otherwise, the percentage of disabled persons on AABD spenddown who meet their spenddown and qualify for a medical card more than once per year, or more than three, six, nine, or twelve times a year. If it is able to stratify the spenddown population in that manner, then the Department should begin with disabled individuals who already meet spenddown more than six times a year (indicating that they have had to submit bills or receipts at least twice (because a large bill or receipt can be used to meet spenddown for up to six months) but less than monthly (because people who meet it monthly are most likely to be receiving ORS or OMH services). We would estimate, based on reports from other states, that as many as 60% of those clients who now meet spenddown more than six months of the year who have spenddown amounts under $30 would be likely to participate in the prepay program. The Department could then apply lower percentage estimates to individuals who either have higher spenddown amounts, or who meet it less often. At the extreme end, where individuals have met spenddown only once in a year, we think virtually none would be likely to participate in the prepay program.

If the Department is not able to stratify clients by how often they currently meet spenddown, then the next best choice would be to stratify disabled (but not aged) AABD clients currently in unmet spenddown by spenddown amount. We are conducting a couple of simple surveys (one at the CORE Center and one at the Howard Brown Health Center) to determine how many spenddown recipients at what prepay level would be likely to participate. Obviously we will forward results from those surveys when we get them. Until then, we would estimate that perhaps 20 to 30% of recipients with the smallest spenddown amounts (under $30) would be likely to participate, with decreasing participation at higher prepay levels. We are happy, of course, to work with agency staff to see what numbers can be generated based on current data.

Thank you again for your commitment to this study and for your determination to complete a report before the end of the year. We look forward to continuing to work with you.

Ann Hilton Fisher

Executive Director
AIDS Legal Council of Chicago

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3645. PAY-IN SPENDDOWN OPTION

Section 4723 of OBRA 1990 (P.L. 101-508) permits you, at your option, to allow individuals, at their option, to spenddown to the medically needy eligibility level through a lump sum payment or installment payments to you. The specific statutory provision establishing this option is contained in §1903(f)(2) of the Act.

A. Before Enactment of OBRA 1990.--Generally, medically needy individuals who must spenddown to meet eligibility standards were required to actually incur expenses to meet their spenddown obligation.

B. After Enactment of OBRA 1990.--With the passage of OBRA 1990, you can now allow individuals to meet spenddown obligations with payments to you, combined with costs incurred in prior months. This is termed the pay-in spenddown option.

3645.1 Pay-in Spenddown Requirements.--After you have elected to provide the pay-in spenddown option in your State plan, you must provide all medically needy applicants/recipients with the option of meeting their spenddown liability through use of the pay-in spenddown, or by using incurred expenses under regular spenddown. Advise recipients to consider benefits of using the pay-in option based on anticipated Medicaid covered expenses during the upcoming spenddown period. Then, recipients can decide for themselves whether it is beneficial to use the pay-in option. Use the same income and resource standards for individuals who pay-in as you do for individuals who incur expenses. (See §3623.) Individuals under the pay-in option are subject to the financial determination of eligibility guidelines described in §§3620 and 3620.1.

> NOTE: 209(b) States that elect the pay-in option must follow Federal pay-in rules and may not use more restrictive rules of their own design.

For comparability, you must use the same budget period for individuals who elect the pay-in option as you use for individuals who incur expenses.

When the budget period is longer than one month, you may allow the individual to pay the pay-in amounts for the full budget period, or in monthly installments.

3645.2 Application of Expenses Incurred In Prior Months.--Prior months' incurred expenses that would otherwise be applied toward the individual's spenddown liability must be used with any remaining unmet portion of the spenddown liability representing the amount of pay-in. (Expenses incurred during the 3 months preceding application described in 42 CFR 435.914 are considered prior months' incurred expenses and are deducted from countable income unless such expenses have been paid by or are subject to payment by a legally liable third party as described in §3628.)

EXAMPLE: Mr. Jones' spenddown liability is $600 for the budget period. He has already incurred $400 in expenses before he elected the pay-in option. Subtracting the $400 prior incurred expenses from the $600 leaves Mr. Jones with a $200 remaining balance as the pay-in amount.

3645.3 Application of Amounts Paid In Toward Spenddown.--The amount paid in by the individual is applied toward reducing the amount of the individual's spenddown liability. It is also used to pay for services received by the recipient during the budget period which are covered and not covered under the State plan. You are not expected to pay for services that are not covered. You must, however, allow use and disbursement of the pay-in amounts for services not covered under the State plan. You may refund unused pay-in amounts (based on the amount that you spent on the individual's behalf) on a case-by-case basis, or you may apply these unused amounts toward any spenddown liability in the next budget period on a case-by-case basis. You may also use both of the options on a case-by-case basis. The decision of which option to use is up to you; not the individual.

3645.4 Federal Financial Participation.--Federal financial participation (FFP) is available only for your expenditures in excess of the amount paid in by the individual. That is, the recipient's spenddown amount must be met prior to services being paid with Medicaid funds, not only for single month spenddown but also for multiple month spenddown periods. (See §3624 for more detailed information on FFP.)

3645.5 State Plan Requirements.--In the State plan, acknowledge the following:

o Your election of the Medicaid pay-in spenddown option for establishing medically needy eligibility;

o That you provide individuals the opportunity to elect or reject the pay-in spenddown option on a monthly or quarterly basis.

3645.6 Administrative Requirements.--The following administrative requirements apply:

o You must provide a written explanation of the pay-in spenddown option to applicant/recipients and you must provide that the election by the applicant/recipient be documented in writing and be retained in the record.

- You must implement reasonable methods of administering premium collections. For example, you must have a means of accepting cash collections for individuals who do not have checking accounts. In cases of payment by check(s), you are not required to provide services until clearance of the check(s) by the bank.

- If a refund is made, you must provide individuals with at least yearly statements which advise them of how much they have been charged for services, how much they have paid toward their services, and how much Medicaid has paid for those services.

APPENDIX F

DPA's Proposal to CMS for a Revised Version of Prepayment

At the direction of the Illinois General Assembly, the Illinois Department of Public Aid is considering the feasibility of adopting the spenddown pay-in option allowed under 1903(f). While there is strong interest in adding this option to our Medicaid program, we believe it could be feasible and, thereby beneficial, to clients only if it is simple to administer.

Following is a brief synopsis of how we might operate a pay-in program. We would appreciate your opinion as to whether these provisions would be approved in a State Plan Amendment. Should you identify problem areas, please advise us as to how we might resolve them.

1. A person could meet spenddown with a combination of medical expenses, including those incurred in prior months, and pay-in only at initial approval.

2. After initial approval, persons could choose on a month-to-month basis whether to meet spenddown by prepaying the spenddown amount or by providing medical expenses. A person could change their option each month. However, within a month, a person could only use medical expenses or pay a premium not a combination.

   The state would establish a cut-off date for receipt of the prepaid spenddown amount. This date would probably fall near the beginning of the month prior to the month of coverage. If the prepayment were received by the cut-off date, the person would be enrolled and receive a medical card prior to the first day of the coverage month. If the prepayment is not received by the cut-off date, the person could only meet spenddown for the coverage month by providing medical expenses.

3. We would accept money orders, cashiers checks, and credit cards. Once we have the capability, we would also accept automatic bank withdrawals. We would not accept any other form of payment, including cash.

4. We would treat the payment the same as an insurance company treats a premium. We would not refund or give a credit for months in which the premium payment received exceeded the expenses paid by the Department

5. We would not reimburse or credit persons for noncovered medical expenses in months in which the pay-in option was used. However, such expenses could be used for months for which the client did not use pay-in.

CMS's Response to DPA's Proposal

Pay-in Spenddown

John this is staff level review of your process. If you want the agency position regarding this matter the material should be submitted formally to CMS.

I have the following comments regarding your synopsis--

Item 3. "We would accept money orders, cashier checks, and credit cards. Once we have the capability, we would also accept automatic bank withdrawals. We would not accept any other form of payment including cash." States must implement reasonable methods of administering amounts paid-in—States must have a means of accepting cash collections for individuals who do not have checking accounts. If accepting checks as payments states are not required to provide services until clearance of checks. Money orders, cashier checks, credit card payments and automatic bank withdrawals would also be reasonable methods of collecting. It would not be reasonable to preclude cash payments.

Item 4— "We would treat the payment the same as an insurance company treats premium. We would not refund or give credit for months in which the premium payment received exceeded the expenses paid by the Department." Application of amounts paid in toward spenddown—states have the option of refunding unused pay-in amounts or applying the amounts to the next budget period. States can also use both options on a case-by-case basis. This option is an alternative spenddown process; it is not a premium process. Therefore, state must refund or give credit for unused amounts that are paid to the state.

Item 5—"We would not reimburse or credit persons for non-covered medical expenses in months in which the pay-in option was used. However, such expenses could be used for months for which the client did not use the pay-in." If a family elects the pay-in spenddown option—amounts paid in must be used for deductions that are required under 435.831(e), this includes expenses for Medicare and other health insurance premiums, deductibles or co-insurance charges, including enrollment fees, co-payments or deductibles under 4447.51 or 447.53, expenses incurred for necessary medical or remedial care services recognized under state law but not covered under the state plan and medical or remedial care services covered under the state plan. Pay-in spenddown is an option in the application of the spenddown process— the spenddown process requires expenses incurred for both covered and non-covered services to be deducted.

Items 1 and 2---After doing some research into the application of the spenddown process we have revaluated our comments regarding items one and two. The manual instructions define "prior months expenses"—as expenses incurred during 3-months prior to the month of application. However, 209(b) states cannot place limits on the age of the incurred expense. Additionally, even though state Medicaid agencies may determine whether and when to require a new written application with supporting information or evidence, the reference to month of application under the spenddown process applies to each month in a monthly budget period case, whether or not an application form is required for the month. Therefore, in states that use one-month budget periods, the state must permit a combination of incurred expenses as well as amounts paid to the state in each budget period.

If you have any questions or concerns please let, us know.

Jackie Wilder

APPENDIX G

Estimated Prepay Spenddown Population by Category of Assistance

Assumptions:
Recipients who met spenddown 75% of FY 2002
Recipients had to be eligible all 365 days in either met or unmet spenddown.
Spenddown uses current CDB values. May be different than when person actually met spenddown.
For AABD the 85% of FPL standard is calculated since that is the standard in effect FY 2002.
AABD population will be affected by SeniorCare and standard increase to 100%
Excludes those who met spenddown with state-paid programs such as DHS Office of Rehabilitation Services In-Home Care Program Services.

SPENDDOWN RANGE	AGED		BLIND OR DISABLED		FAMILIES	
	PERSONS	AVERAGE SPENDDOWN	PERSONS	AVERAGE SPENDDOWN	PERSONS	AVERAGE SPENDDOWN
$25 OR LESS	162	$12.31	316	$12.31	22	$17.09
$26 - $50	135	$39.31	287	$38.07	24	$34.71
$51 - $75	107	$62.52	217	$62.34	37	$62.46
$76 - $100	88	$87.97	175	$88.28	15	$87.80
$101 - $150	157	$128.36	308	$124.45	23	$122.00
$151 - $200	112	$174.60	197	$173.48	14	$178.93
$201 - $250	78	$222.17	143	$226.05	13	$231.46
$251 AND MORE	174	$430.10	586	$581.35	176	$782.11
	1,013	$151.63	2,229	$219.51	324	$465.46

Total All Categories Of Assistance	3,566	$222.58